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Bulletin of
THE MENNINGER CLINIC

VOLUME 5 NOVEMBER, 1941 NUMBER 6

THE MENNINGER FOUNDATION FOR PSYCHIATRIC EDUCATION AND RESEARCH

AN ANNOUNCEMENT

Plans for mobilizing the country for defense, involving billions of dollars for training soldiers and manufacturing armament, ships, airplanes and tanks, recall to the physician the unexpectedly important role that psychiatry played in the First World War. It was a need almost entirely unanticipated. Surgeons, internists, ophthalmologists—these and many more specialists were called upon as a matter of course to lend their services to salvage as many men as possible from the results of war. But it was the psychiatrists who demonstrated that their function in war was almost as extensive as that of the army surgeons, and little less spectacular. Thousands of soldiers with war-induced mental disturbances were referred to hastily organized psychiatric centers, not for mere labelling, diagnosis and seclusion, but for rapid rehabilitation. Thousands were sent promptly back to active service healed of mental wounds no less incapacitating and searing than physical wounds.

This practical demonstration of the therapeutic efficacy of psychiatry on a large scale was immensely significant because it marked the emergence of a new concept. Psychiatry no longer consisted of the diagnosis and segregation of the hopelessly afflicted; its therapeutic possibilities and their application to all human beings were established. From keepers of the insane, psychiatrists became counsellors of the maladjusted, the distraught, the inefficient, the unhappy.

In 1917 when the A. E. F. sent back to this country a frantic call for more psychiatrists for the front, they were not available. And strange as it may seem, if the same call were issued today the shortage would still exist. For the training period for psychiatry is long, facilities are lacking, and financial rewards, in spite of popular notions to the contrary, are small in comparison to other specialties in medicine.

With the end of the war the usefulness of psychiatry was again

largely limited to its application in private practice to a few individuals. The vast opportunities for research and for wide application afforded by the war were curtailed. Millions of dollars have since been put into research in physics and chemistry, which have had their practical expression in the production of automobiles and radios as well as arms and battleships. A smaller but still considerable amount of money has been put into medical research, so that we now have adequate defenses against such former scourges as smallpox, typhoid fever, syphilis and pneumonia. But those diseases in which psychological factors are important—for example, high blood pressure, stomach ulcer, arthritis, and goiter—remain largely unsolved and unsatisfactorily treated. This is partly because only the smallest fraction of the investment poured into physical, chemical and biological research has been placed at the service of psychological research.

Thus it is that the practical contributions which psychiatry and psychology could make to medicine, to business and industry, to the solution of our two greatest problems—unemployment and war—to human happiness and health, are unrealized. In an age that exalts science and urges preparedness, it seems inconceivable that this branch of medicine should be utilized so ineffectively.

Quite apart from the contingency of war, psychiatry faces a great national emergency. One-half of the 500,000 hospital beds in this country are occupied by psychiatric patients; approximately 1000 psychiatrists attempt to care for this vast group; while for all those cases of unhospitalized psychoses and the even greater number of neuroses and character disorders in the rest of the country's population there are only about 1,000 more psychiatrists. It is apparent that with this shortage of psychiatrists, good psychiatric care for millions of people who need it is not available. It is emphatically true, as Raymond B. Fosdick stated in his 1938 report to the Rockefeller Foundation, that mental hygiene represents one of the most under-developed areas in all medicine. "In no other field," he continued, "is the need more desperate or the potentialities for useful advances more promising. It is not necessary to recall the fact that cases of mental and nervous diseases occupy more hospital beds in this country than all other diseases combined. One has only to look about him at the tragic examples of human maladjustment and inadequacy in everyday life. Because the field is relatively so difficult, it has lagged far behind other developments in medicine."

Sigmund Freud was looking far ahead to this problem when in the fall of 1918 he addressed these words to a psychoanalytic congress:

"We are merely a handful of people and even if we strain ourselves to the utmost we can only treat a small number of patients each year. In comparison with the vast amount of neurotic misery in the world—which perhaps need not exist—our efforts at its alleviation are quantitatively negligible. . . . For the broad masses who suffer acutely from neuroses we can at present do nothing. . . . But one day the conscience of society will awaken, and we shall realize that the poor man has the same claim to psychotherapy that he now has to surgical aid. And we shall also come to see that the neuroses menace the health of the people no less than does tuberculosis, and that, like tuberculosis, the neuroses cannot be left to the ineffectual care of the individual himself. When that time comes, institutions and consultation centers will be established and staffed with psychoanalytically trained physicians, so that men who would otherwise give way to drink, women who might break down as a result of overwhelming deprivations, and children whose choice would be limited to delinquency or neurosis, may be strengthened through psychoanalysis to resist such unhealthy tendencies and become capable of social achievements. Such psychoanalytic treatment will be free. It may be a long time before the state regards this as its urgent duty, and present conditions may still further postpone action. Probably such institutions will first be started by private philanthropy. But one day they will be established; they must be."

Such monumental contributions to the welfare of mankind as the Rockefeller Institute of Medicine, the Mayo Foundation for Medicine and Surgery, the Carnegie, Massachusetts and California Institutes of Technology, and similar institutions deserve our highest commendation. But in contrast to these magnificent developments, the lack of a central institute for psychiatric research is a silent, sad reproach, not only to our humanitarianism but to our scientific progress.

NEED FOR A PSYCHIATRIC INSTITUTE

These needs led us to visualize a centrally located American psychiatric institute in which competent research men could apply themselves to these deep psychological, medical and social problems, one in which experienced teachers could inspire and instruct younger physicians, and in which selected patients who wished to have the most

highly developed methods of psychiatry applied to their personal conflicts could be brought together under the proper auspices. The work thus done would be coordinated with that of other psychiatric groups and with other scientific research projects in medicine, industry, sociology and education. In this way there would be afforded the opportunity to carry out certain definite functions, some of which are sketched briefly below:

1. Training of Personnel

Competent well-trained men cannot be supplied upon a moment's notice and will not be available when emergencies which imperatively require them arise. Once let industrialists awaken to the usefulness of the application of psychiatry to personnel problems, once let the teachers see what psychiatry could offer for the improvement of our unsatisfactory educational methods, once let thinking people realize what a better understanding of human nature could do in combating unemployment, intolerance, religious fanaticism and mass hysteria—and there would immediately be a demand for psychiatric services a hundred times greater than the present supply. Such an awakening to the need for the application of psychiatry in these varied fields of human life is imminent. The facilities now existing for undergraduate training in psychiatry do not suffice for even the present demand. Psychiatry like surgery is a postgraduate subject. From three to eight years are required for adequate training. Applicants must be carefully selected, for every physician who is interested is not acceptable. Psychiatric education requires an opportunity for psychiatric experience and this should be obtained through the care of thoroughly studied psychiatric patients—not in the handling of thousands of inadequately treated cases as in state institutions, or in the catering to a few individuals luxuriously housed in private sanitariums.

Even more important than scientific facilities is the need for inspired teachers. The capacity to communicate inspiration is the gift of but few teachers and only a very few of the university medical schools in the United States can be said to inspire their students to see the usefulness and opportunities of psychiatry. This is not a reflection on the universities, but it is an indication of their limitations in the training and development of men in specialized fields, particularly in pioneer fields.

In addition to the need for more trained psychiatrists, there is another problem in postgraduate psychiatric education which has not been met. Practicing physicians and teachers in medical schools recognize that medical conceptions are rapidly changing and that many, if not most, of the conditions which the general practitioners and some of the specialists treat can be understood adequately only when the emotional conflicts of the patient are taken into account. Yet most medical men now in practice have had no training in the technique of such investigation and do not know where to secure such experience. A psychiatric institute could prepare a postgraduate program of theoretical and practical instruction which would vastly improve the clinical or teaching functions of such men who have already developed their special interests in other fields of medicine.

2. Research

Psychiatry cannot move forward on the basis of practicing merely what is already known. There exists an infinite number of problems which must be investigated more thoroughly before they can be of practical use—medical, educational, industrial, social and personal problems. For such research an institute would make available to those psychiatrists and psychologists who showed aptitude, an organized and directed program with adequate facilities for formulating specific problems and testing data.

3. Treatment

Since the material of psychiatric research and training is the human being, there must be opportunity for the treatment of a representative group of patients, selected not for their ability to pay but for their specific needs and their intelligent cooperativeness. It is well known that there are few places for people of average means (teachers, ministers, lawyers, physicians, tradesmen, "white collar" employees) to go for psychiatric help, although they are usually the persons who desire it most and are more appreciative of it. Research institutions need such patients and can give them the assistance they seek. If it were possible to offer good psychiatric service at low cost, larger numbers of these people could be treated and restored to greater usefulness without the emotional shock and embarrassment, as well as the financial loss to their employers and families, of being confined in

state hospitals. At the same time the knowledge of psychiatry in relation to everyday problems could be extended.

4. Prevention

Much has been accomplished in the field of preventive medicine but not as it pertains to psychiatry. "If anything affects your eye you hastens to have it removed; if anything affects your mind, you postpone the cure for a year," is a quotation as applicable today as it was in the days of Horace (who said it). It would be more accurate, however, to say that treatment is usually postponed not for a year but for two or three decades. It has been proved and is now universally accepted that adult maladjustments, neuroses and psychoses have their inception in childhood. Yet the exact nature of the conditions under which mental illness is fostered, and the manner in which the personality of the child is warped, are not discerned by parents or educators because of the great complexity of interacting factors, which differ in every individual. No field of research promises more for the good of mankind than adequate scientific child study; yet, in spite of the vast amount of advice and counsel that is offered today on this subject, it has been left for the most part to well-meaning but poorly trained investigators. This is largely because of the lack of psychiatric laboratory schools where children can be educated in the true sense of the word.

The possibilities outlined in the preceding pages as functions of a central psychiatric institute, have all been undertaken and carried forward here for a number of years by the Menninger Clinic and its associated organizations, the Menninger Sanitarium and the Southard School. They have been developed and financed entirely by private initiative, with the exception of one grant-in-aid received from the Rockefeller Foundation and a few personal gifts from friends and patients. The work has been, however, greatly handicapped by lack of funds, since many of the activities, including all of the research and part of the treatment and education, produce no income.

The chief difficulty in the way of obtaining capital to maintain these activities properly has been the lack of a receiving agency to administer funds donated under the provisions of the federal laws governing income tax and gift deductions. This difficulty has now been met by

the organization of a psychiatric foundation as a non-profit corporation.

On April 22, 1941 the incorporators of *The Menninger Foundation* made application for a charter, stating that "The objects and purposes to be transacted and carried on are: The acquisition by deed, devise, bequest, gift, purchase or otherwise of real and personal property, and to hold, invest, reinvest, manage and dispose of the same for the purpose of promoting medical science and especially the development of psychiatry and its related sciences; providing opportunities for scientists to apply themselves to research in the problems of medicine, psychology and sociology; providing for the instruction of physicians, nurses, therapists and educators in a broad and intensive understanding of the human personality; providing treatment for patients whose funds are inadequate; studying the conditions under which mental illness is fostered and the manner in which the personality of the child may be warped; studying and developing the application of psychiatry to education, industry, preventive medicine, political science and sociology."

The charter was granted on April 26th and on April 30th the first meeting of the incorporators and trustees of *The Menninger Foundation* was held in Topeka.

The following trustees have been elected: Mrs. Sidney C. Borg, Jewish Board of Guardians, New York City; Mr. Warren M. Crosby, Warren M. Crosby Company, Topeka; George E. Hite, Jr., Milbank, Tweed, and Hope, New York City; Dr. Robert P. Knight, The Menninger Clinic, Topeka; Mrs. Albert Lasker, New York and Chicago; Mrs. Lucy Stearns McLaughlin, Santa Fe, New Mexico; Dr. Charles F. Menninger, The Menninger Clinic, Topeka; Dr. Karl A. Menninger, The Menninger Clinic, Topeka; Dr. William C. Menninger, The Menninger Clinic, Topeka; Dean J. Roscoe Miller, Northwestern University, Chicago; Mr. David Neiswanger, Neiswanger Investment Company, Topeka; Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C.; Mr. John R. Stone, The Menninger Sanitarium, Topeka; Dr. John C. Whitehorn, Johns Hopkins University, Baltimore.

Dr. Karl A. Menninger was elected President; Mr. John R. Stone, Vice-president; Dr. William C. Menninger, Secretary; and Dr. Robert P. Knight, Treasurer.

In the next issue of the Bulletin a brief statement of the activities already initiated by the Foundation will appear.

SHORT PSYCHOANALYTIC PSYCHOTHERAPY: ITS POSSIBILITIES AND ITS LIMITATIONS

By Bernhard Berliner, M.D.*

Psychotherapy based on psychoanalytic principles is a very controversial subject. However, I believe there is general agreement among psychoanalysts on three points:

1. that there is a tremendous need for short psychotherapeutic treatments to help those patients who can not afford a full-course analysis;

2. that the psychoanalytic method is the method of choice in the treatment of neuroses;

3. that a method of short psychoanalytic psychotherapy must in no way forestall a long full-course analysis if the case turns out to be one which cannot be sufficiently helped with an abbreviated procedure. It should be possible in those cases to carry over the originally intended short treatment into a regular analysis.

At present, we have no definite criteria which will enable us to determine beforehand whether a case is suitable for short psychoanalytic psychotherapy. It is the task of this paper to try to point out some indications and contraindications for this type of treatment.

What I mean by "short psychoanalytic psychotherapy" is a true psychoanalytic procedure, not to be confused with the methods of some of the so-called Stekelian "active psychoanalysts" who guess or grasp interpretations which may be correct but not yet comprehensible to the patient and try to persuade the patient to accept them. We disagree with such a method. What I have in mind is a successful first phase of a real analysis which helps the patient to come to terms with his most important problems. This phase may be extended and supplemented as may be deemed necessary.

There are patients who live out of town but can see us regularly for some weeks or months. We have to do what has been called a fractional analysis. I have found this method very satisfactory in some cases. When we have to close a period of treatment we can not dismiss the patient, as it were, with an open wound. We must achieve a

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certain preliminary result to be aimed at from the beginning. This means that the fractional method is a modification of the classical analysis not only in the time arrangement but also in the technique during each period of treatment. This method is similar to short psychoanalytic psychotherapy. From the start we aim at a practical result by which the patient is helped for the time being, even if the help is only preliminary.

Our task is to understand as quickly as possible the essential problem and to make it understandable to the patient. In order to help the patient to master his problem we have to be more active as therapists than we are in a classical analysis. However, we are always analytically minded, keeping our interpretations on a level which is understandable to the patient and at the same time avoiding any penetration into deeper, not yet understandable layers.

A case may illustrate this. A young executive picked a quarrel with his superior and came for treatment terrified by the prospect of losing his job and his whole career. In retrospect he was aware that the quarrel was quite irrational and incomprehensible to him. In a few interviews, in which he showed the traits of a masochistic personality, a severe father conflict was revealed. He understood the transference nature of his conflict with his superior and was able to see that this man "was not the enemy." This particular actual conflict was solved; he succeeded in apologizing, for which I gave him some practical hints, and established a good relationship with the older man. But soon another conflict came up. He had to take a very difficult examination for promotion in his legal career. A severe examination fear developed with the idea of dropping his whole career. Again the father transference and his reenacting of an old spite and guilt reaction could be demonstrated to him, whereas the obvious castration anxiety had to be kept out of the discussion.

Then there was another complication. A love relationship provided an escape from the fear of examination. He behaved toward his girl friend in an intensified regressive infantile way. There was a passive indulgence in preliminaries and masturbatory acts in which he found much more comfort than in intercourse which gratified him but little. The acute examination problem did not allow us to proceed with the analysis of his Oedipus and castration complexes. I demonstrated to the patient the escape nature of this love affair and the narco-

tizing effect of his passivity upon his anxiety, but avoided a penetration into the id-material of his mother relationship. In terms understandable for the layman I explained to him the idea of sublimation and how his sexual energies could be put to the service of his work, and I advised him and his fiancee to discontinue the love relationship until after the examination and then to manage it in a more mature way. A mild super-ego function thus assumed by the analyst helped towards a release from guilt feelings and towards a liberation of the aggressive drives. The treatment took some weeks with one, occasionally two hours daily. There was an intense, sometimes eruptive flow of childhood material to which interpretations were given only as far as a confrontation with the actual problems could be made. The therapy was a complete success, and no further analysis was necessary. The patient reported occasionally to me for several years.

Of course, this was a particularly favorable case. Although much supporting encouragement was used, particularly during the time of examination, the main therapeutic instrument was the analytic elaboration of the patient's early father relationship and his defense reactions.

I admit that the technique used in this case may simply be called psychotherapy as practiced by a psychoanalyst. However, it is a true psychoanalytic method in so far as it consists of an analysis of defense and transference mechanisms and a part of the libido structure of the patient and the application of this analysis to the understanding of his actual conflicts.

Masochistic conditions, if not too severe, have proved to be a good field for this procedure. I follow the point of view of my recent paper.[3] If it is possible to give the patient a quick understanding of his libidinal relationships to those original super-ego persons who caused him to suffer and of the substitute gratifications which he derives out of his unhappiness; and if his hidden aggressions and drives towards a compensatory superiority can be convincingly demonstrated to him, a good result can be obtained in a comparatively short period of time. Although not all his suffering can be alleviated, he can be greatly benefited in his orientation to society and to the persons near to him. Marital difficulties based upon masochistic reactions are a particularly good indication for this type of therapy. Many of the successes which Adler's individual psychology produces are based upon the demonstration to the patient of how he tends to recoin masochistic

inferiority feelings into a pseudo-superiority. However, psychoanalysis with its emphasis on the libido structure can do a better job in the same amount of time. If we can give a dynamic interpretation of how the masochistic sense of guilt serves the infantile pattern of searching for love, the resistance caused by it can be effectively attacked. However, deep unconscious feelings of guilt which lead to negative therapeutic reactions are an obstacle to an abbreviated analysis. If the masochistic person understands that his irrational suffering as well as his disguised aggressions mean an enormous waste of positive psychic energy, he can be led, by supporting encouragement, to a more constructive use of this energy. We can help him toward a better method of reality testing and a strengthening of his ego in relation to obsolete infantile libidinal tendencies. We bear in mind that masochism is a libidinal *re*action and has to be understood in terms of what it is a reaction to. The assumption that masochism is the expression of a primary instinct, the death instinct, condemns one to therapeutic ineffectiveness.

There are mild cases of obsessional neuroses which can also be helped by this short treatment, if the underlying aggressions can be brought into consciousness and confronted with the symptom with consecutive guiding or educational influence. For example, a young mother was troubled by the obsessional thought that she might cut the throat of her baby boy. During her pregnancy with this baby, her father had committed suicide by cutting his throat. The discussion of her ambivalent feelings toward her father, her sadistic impulses and her guilt reactions brought great relief within a few weeks.

Another example: a married woman had an irresistible drive to pick quarrels with her husband. The masochistic relationship to her mother whose ambitions and educational rigidity were accepted and acted out towards the husband was already in the preconscious. The blocking of her capacity to love her husband could be demonstrated without detailed reference to the Oedipus complex, and the woman as well as the marriage were greatly helped by eleven sessions within three months.

Masturbation fear with inferiority feelings resulting from it, and secondary defense reactions against them may bring about a clinical picture which simulates schizophrenia. A young man of 24, an artist, came for treatment with the following complaints: he felt isolated,

out of place everywhere, awkward, self-conscious, and disgusted with his work; he had "lost his sense of personality" and his "creative faculties"; he had to lean on others and mimicked even the facial expressions, gestures, and attitudes of other persons. He felt that he was "going to lose his mind." There were mild compulsions, e.g. impulses to touch telephone poles. His work suffered on account of affect inhibitions; he "could not feel or see anything." Social and erotic contacts were extremely difficult. The case was previously diagnosed as schizophrenia on account of the apparent blunting of emotional reactions and contacts, as well as certain mannerisms such as imitation of other person's attitudes and a peculiar pseudo-intellectual way of speaking and writing which was circumstantial and full of unusual and polished-up words and phrases. Although there were no delusions or hallucinations, the case nevertheless made an impression of serious personality involvement. The whole picture turned out to be one of fear, guilt, and inferiority feelings as reactions to masturbation and the castrating and ridiculing attitudes of the patient's father. The schizophrenia-like picture was a mask to cover his inferiority feelings. After 18 sessions distributed over 8 months, in which his actual behavior, his reactions to sex, to masturbation and to his father were discussed, the patient was practically restored to normality.

Many cases of impotence in the male can be successfully treated in a short course. I have had quite a few cases which may be called monosymptomatic neuroses, in which only the disturbance of the potency motivated the patient to seek help and the general neurotic condition was practically negligible. Many of these cases do not need a full analysis of Oedipus, castration, and incest motives, oral and anal conflicts, homosexual complications, etc. at their source in early childhood. It is frequently sufficient to discuss the phenomenology of the later derivatives, especially those appearing in puberty, and to demonstrate their meaning as defense reactions. There are three groups of manifest symptoms which occur with great regularity: 1. A struggle for total repression of sexual stimulations with ethical, aesthetic and religious rationalizations, leading to an ascetic or puritanical attitude of obsessional character. 2. Displacement of the sexual object into phantasies of a more or less auto-erotic kind which interfere with the activation of the libido to the real object. The patient usually understands that his phantasies provide too strong a competition with his real love

object. 3. Displacement of the sexual aim into the preliminaries, a short-circuiting of gratification in the process of forepleasure. This group comprehends all the cases of premature ejaculation. The detailed discussion of this conscious or preconscious symptomatology, re-enforced by instructions about normal psycho-sexual life as well as by encouragement, is frequently sufficient to achieve success. Psychoanalytic understanding is more important than the full psychoanalytic technique in those cases in which there is a great amount of preconscious material. However, if necessary, one may go into the deeper strata of the unconscious at any point of the treatment. The whole discussion takes place, as it were, before the half-open doors of the unconscious.

I have tried the short method, but never succeeded with it in cases of frigidity in the female. This condition has a more complicated structure with deeper roots in the unconscious and, particularly, with much stronger resistances. All my cases needed a long analysis.

Organ neuroses may be good objectives. A man of 31 was referred by the medical clinic for treatment of attacks of stomach pain of the ulcer type without physical findings. The attacks began 7 years before he came to see me as a reaction to the unloving and frustrating attitude of his wife. His mother had died of an abdominal condition when he was seven. He remembered that she had a very swollen stomach; "they took water out by the gallons." He was raised by the maternal grandmother who died 5 years ago. The grandmother had meant everything to him and he had grieved ever since she died. When he was ten his father had remarried, which the boy resented very much. He felt that he was in the way. The patient's wife had a strong and superior father and the patient felt he could not live up to her ideal; he wanted to be more a child than a father to his wife. She expressed the idea that he never grew up and she objected to his playing with the children. He liked to drink thick milk shakes and to eat large amounts of sweets which frequently precipitated the stomach pain. The patient was given the interpretation that his stomach trouble was a reaction to the loss or the lack of motherly love which he craved. He was encouraged to overcome the need for being loved in the way in which a child is loved by a good mother. He developed a good understanding of his infantile and oral attitudes and realized the necessity of developing a more manly attitude towards

his wife and his children. After four interviews in a period of five months the patient was completely cured of the stomach pain and was changed into a person of the amiable and well integrated oral type.

How can we define a case as suitable for short psychoanalytic psychotherapy?

The first answer is that ego resistances must be at a minimum. No patient, for example, is more cooperative than a man who seeks help against the isolated symptom of impotence without being an outspoken neurotic in general. The same holds true for patients with greatly ego-alien phobic and obsessional symptoms.

Second, there must be a good positive transference during the whole period of treatment so that no time has to be spent on transference analysis. Of course, transference analysis is done immediately when it is indicated (that is when a resistance arises from it). But it needs more time and the treatment may take the course of a full analysis. The amount and the power of transference resistances is a decisive factor in the question of the feasibility of a short treatment. The analyst has to do his share in keeping the transference positive. However, *I am definitely opposed to any kind of arranging or making up or forcing the patient into a particular transference situation.* To do so means to take chances which, in my opinion, are beyond our competence and responsibility.

Besides the positive transference and related to it, the patient's narcissism is of help. The best reactions are found in those cases in which the treatment gives the patient a continuous narcissistic satisfaction without those temporary blows to his narcissism which we are accustomed to see in every long analysis. The support of his narcissism leads to a strengthening of his ego and finally to the dissolution of the transference. The patient learns to objectify his problems and to obtain a perspective on them.

Third, cases with considerable secondary gains and neurotic gratifications from symptoms are not suitable. They need longer and deeper analyses. However, more superficial secondary gains are sometimes an excellent hinge for a psychotherapeutic influence. The stress on the unconscious purpose of a neurotic condition stimulates many a patient's interest and cooperation.

Fourth, in more severe cases which need a long analysis, certain partial successes may be attained in a short period of time if one can

approach the masochistic mechanisms involved, as I have previously outlined, and if the patient is sufficiently cooperative.

Knight[1] pointed out that acute cases offer the best chance of success. In my experience this is not quite so. In some of my cases the illnesses were of a considerable duration and others were only acute reactions on the base of a broader neurotic disposition. The feasibility of a short treatment does not depend on the acuteness and duration of the illness but on the depth of the neurotic disposition.

The technique is pre-eminently one of ego analysis including the ego-near parts of the super-ego. The mode of procedure is either the classical technique on the couch or a simple conversation, depending principally on how the patient feels about it. "Free associations" are an exception during the initial period of an analysis anyhow, and are of no particular help in the short treatment, except in dream interpretation. The patient is encouraged to talk as frankly as possible. In giving interpretations, we confront the patient consistently with the reality ("this is not the enemy", as in the case of the young official), in order to aid his reality testing, and to make him realize his preconscious ego defenses which are mainly responsible for his difficulties. The study of the repressing forces is more essential than the investigation of repressed material. As soon as an extensive analysis of id-material is necessary the treatment will automatically steer into the course of a full classical analysis. In the short course, libidinal tendencies are referred to only in so far as the patient's ego can understand them immediately, and can tolerate them.

One recalls in connection with short psychoanalytic psychotherapy the old cathartic method with or without the aid of hypnotic technique. I have tried this method in seemingly appropriate cases through many years in the past, but could not gain confidence in it. When it seemed that a dramatic abreaction took place, the next day often brought a disappointment in the form of increased anxiety and resistance. In other instances I found myself confronted with an acute danger of suicide and had to stop the abreaction there and then. The ego is not sufficiently taken into account in this procedure. I feel this method should be left to history.

I want to stress the point that what I call psychoanalytic psychotherapy must not be confused with a procedure which attempts to free the patient from a symptom only. The principle which I have

in mind is to understand within a short period of time the central problem of the patient from the point of view of his libido situation and to make it understandable to him in a way his ego is able to accept. To cure only a symptom without a sufficient alteration of the underlying condition is dangerous, because new symptoms may grow upon the old ground which may be more severe than the original one.

I regret that my case histories which corroborate this statement are not suitable for publication. Reviewing my experience, however, I find that all my patients who reacted to the removal of a symptom with the new formation of other more dangerous symptoms were individuals with a strong oral disposition and oral fixations. An adolescent boy with an ambivalent mother fixation was cured of stuttering, but, out of his unsolved Oedipus and castration complexes, he developed severe character difficulties with oral symptoms such as drinking, gambling, borrowing and wasting money, etc. An alcoholic was enabled, through social pressure and psychoanalytic psychotherapy, to stop drinking, but a new stroke of hard luck which previously would have caused him to drink made him commit suicide by drowning. Drug addicts, when they succeed in abstaining, are in a similar danger. The dissimulation of a depression under suggestive influences may also result in a disconcerting surprise. The new formation of an oral symptom under transference influences was very striking in a case which I published some years ago.[4]

The quick removal of a symptom is a result of transference which is best achieved under a state of positive mother transference to which persons with an oral disposition are particularly inclined. Persons of this type are sometimes almost "transference-addicts". They absorb friendly transference influences readily. When they listen to the therapist they often show a shape of their mouths as if they were sucking. They are easy to guide, in contradistinction to persons of an anal disposition. However the result of this guidance remains superficial. The old ambivalence pattern is always ready to get the upper hand, and the defense reactions may be driven into deeper levels. Neurotic symptoms of oral origin are rooted in the deepest layers of the personality structure. They require great caution, and their quick disappearance must be judged with reservation. Cases of this kind are no objectives for a short psychotherapeutic treatment, because the psychological condition which underlies the symptom is too remote

from an easy access. On the other hand, neurotic symptoms evolve in the service of self-preservation. Removing them before they are dispensable for this purpose carries with it great responsibility.

It may be mentioned in this connection that the peculiar change which the picture of hysteria has undergone during the last few decades is an example on a large scale of this vicissitude of symptoms. The strange theatrical show which hysterics used to make in previous times became a public disgrace and disappeared from observation; but hysteria was not cured. Instead the neurotic tendencies took on a more self-destructive character.

In the cases to which I referred, the disappearance of the symptom was a true therapeutic success, however incomplete. It must not be mistaken for the well-known phenomenon of "escape into health" out of resistance. These are the cases in which the analyst, as Freud said, has the seemingly un-medical duty of keeping the patient ill for a period of time in order to keep him cooperative in the analysis. They are, of course, also a contraindication for any abbreviated treatment.

This seems to be the most important consideration in the problem of short psychoanalytic psychotherapy: to evaluate the depth and the necessity to the patient of his neurotic symptoms. Our supporting and guiding psychotherapeutic activity ought to be directed only against those conditions which necessitate the symptom. This kind of psychotherapy can only be analytical. No compromise is possible here. If we do not succeed quickly, then we have to take time for a complete analysis.

BIBLIOGRAPHY

(1) Knight, R. P.: Application of Psychoanalytical Concepts in Psychotherapy: Report of Clinical Trials in a Mental Hygiene Service. *Bull. Menninger Clin.* 1:99–109, Mar., 1937.

(2) Crank, H.: The Use of Psychoanalytic Principles in Out-Patient Psychotherapy. *Bull. Menninger Clin.* 4:35–40, Mar., 1940.

(3) Berliner, B.: Libido and Reality in Masochism. *Psychoanal. Quart.* 9:322–333, 1940.

(4) Berliner, B.: The Psychogenesis of a Fatal Organic Disease. *Psychoanal. Quart.* 7:368–379, 1938.

THE CHILDREN'S WORLD IN RELATION TO THE SCHOOL PROGRAM*

By Robert J. Havighurst†

Somewhere between the ages of five and seven every American boy and girl trudges off one September morning into a new world—the children's world. The bolder ones go alone. But for them it is no less a doubtful venture than for the timid youngsters who must have the reassurance of mother's hand and presence for the first few days. Starting to school is the most important event of childhood.

Coming from the small, close-knit family group into the loose, impersonal classroom group is a confusing experience. The crowded schoolroom lacks the homey atmosphere of affection provided by father and mother and older brothers and sisters, which makes the bosom of the family a place where mistakes can be made without serious consequences and weakness can be shown without shame. The thing that marks off the schoolroom as a new world is the presence of twenty or thirty other children, mostly strangers, mostly rivals. With these other children one must learn to get along, to make friends, to make enemies, and on occasion to put up a front so as to cover up wounded feelings.

It is a new task that confronts the school child, the task of establishing himself with his peers. He must learn a role, or several roles, suitable to his sex and age. He must learn the games that are suitable for his sex. He must learn to be a leader or a follower. He must learn to play with friends, or, if he is the kind that does not make friends, he must learn how to be busy, though solitary, and to cover up any desire that he may have for playmates.

The children's world, into which the child enters when he starts to school, is created by children. It possesses a culture, with its own approved modes of belief and conduct. This culture is passed on from the elders to those next in line, with relatively little change. The

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children's games and folkways appear to be less changed by technological and social change than are the parallel activities of adults.

As the child enters the children's culture, he also enters the school program. This program is designed by adults. For ten or fifteen years the school program and the children's culture will act, side by side, as important influences in the life of the child. Sometimes in opposition, sometimes in collaboration, they will do much to form the child's character, to crystallize his attitudes, and to train his intellect.

The purpose of this paper is to discuss the functions of the children's world in the life of the child and to show how the school program may supplement and correct (where necessary) the influence of the children's world.

FUNCTIONS OF THE CHILDREN'S WORLD

It seems proper to say that children have a culture of their own. The children's society possesses its own characteristic ways of thinking and behaving, which change from one age level to another, but are alike in their influence over lives of children. This culture is sometimes called the *peer* culture to distinguish it from the adult culture which also influences the child.

The peer culture increases its influence over children's behavior as they grow older until it reaches a peak during adolescence. The adolescent needs the moral support of his peers in becoming independent of his family, and in return for this support he practically becomes the slave of his peer culture. But there is no sharp increase at puberty. Already by the age of ten a boy or girl wants to wear the same clothes, eat the same food, use the same slang, and play the same games as his peers, and he will fly into a rage if his parents or teachers try to convince him that he should be "different." By the age of eight a boy or girl is concerned about having friends, about what his peers think of his size, his looks, and his ability at games.

The elementary-school period can be thought of as a period of steadily increasing influence of the children's world over the feelings and behavior of boys and girls. Age-group standards are steadily becoming more important compared with standards of parents and teachers. Child-child relationships, though never as profoundly influential in the child's personality as child-parent relationships, grow relatively more significant.

Anyone who would understand the children's culture would do well to start with a study of children's games. These are subject to a minimum of adult influence and interference. Children become "wrapped up" in their games, which certainly are a most significant factor in their development. Marbles is a very good game to study.

The game of marbles is found everywhere that children of the European-American civilization are found. This game flourishes in the spring of every year, appearing just ahead of the buds on the trees. Although it has many variations, it seems to change but slightly from one generation to the next.*

Some variations of the marbles game are very complex, with sets of rules as intricate as Latin or German grammar. The fact that boys of ordinary intelligence learn them with little apparent effort is evidence of the influence of strong motivation on learning. Youngsters of five or six years play the simpler forms of the game and imitate the more complex forms without knowing clearly what they are doing. By the age of eleven or twelve they know the rules perfectly and commence to experiment with new rules or to adapt old ones to fit changing circumstances.

It is a striking fact that children's attitudes to the rules of the game of marbles differ from their attitudes to the ordinary rules of behavior laid down for them by adults. The writer observed this difference in a seven-year-old youngster who was quite immature in his attitudes toward the rules laid down by his parents. Furthermore, he often acted like a baby in his relations with a nine-year-old brother with whom he quarrelled a great deal, often crying and seeking the help of his parents when he was making some unfair demand on his older brother. When the two boys were playing marbles, the situation was entirely different. The younger boy took his losses coolly, played strictly according to the rules, and never sought an unfair advantage.

* For example, there is the rule of "snatches," or "squabs" as it is called in Chicago. The writer remembers this rule from his boyhood days in central Illinois. According to this rule, when ownership of a marble or a group of marbles is slightly in doubt, or when there are many boys around with no marbles and the game is lagging because of too few players, someone calls "squabs" and there is a scramble for the marbles that are on the ground. This is really a provision for redistribution of property, to keep the institution of marbles going when a few people corner all the property, and to keep the propertyless proletariat satisfied and in the game. It is amazing that this potentially "lawless" procedure is kept within bounds to the satisfaction of all concerned.

The observer got the impression that the rules of the marbles game had an entirely different status in the eyes of the boy from the rules of conduct laid down by the parents. He behaved as an adult toward the rules of the game, while he was still a baby with respect to the rules his parents made concerning his conduct.

It might be guessed that there is a characteristic difference between the child's developing attitudes toward the rules which are a natural part of the children's world and his attitudes toward rules which are imposed upon him by the adult world. It might also be guessed that as children grow older they incorporate some of the adult-imposed rules into their own children's culture and obey them with the same alacrity as they obey rules of games. In other words, there may be some clues in the study of rules in the children's world to the all-important problem of the development of children's moral ideas.

Several people have looked for such clues. The most notable work along this line has been done by Jean Piaget, the Swiss-French psychologist. He studied children's ideas about the rules of various games, including marbles, and he also studied children's ideas about the goodness or badness of various kinds of conduct. We shall give a summary of his findings and of his conclusions concerning the development of morality in children.

Our problem is—How does the child become a moral person? We know that parents and parent-surrogates are important in this process. They set the first rules and make the first definitions of right and wrong that the child encounters. They are all-powerful in the eyes of the child, and, furthermore, the child loves them. Therefore, the child obeys their rules and accepts their moral judgments, for the most part without question. This kind of morality Piaget calls *morality by constraint*. Through telling children stories dealing with punishment, moral behavior, and moral responsibility, and asking for their reactions to these stories, Piaget found that for most children between the ages of six and eight rightness and wrongness are definite, objective things. The adults know what is right. Motives are not important. The rightness and wrongness are in the objective good and harm done. For children at this same age level, the rules of such games as marbles are sacred, unchangeable entities.

But as children grow older, their attitudes toward rules and their ideas about right and wrong undergo a considerable change. After

boys are about ten, the rules of the game of marbles are understood to be a matter of mutual agreement, and they are no longer thought to be sacred and unchangeable. They may be and often are altered by mutual consent. Similarly, ideas of right and wrong become more relativistic. It is understood that the rightness of an act lies partly in the motives of the person committing the act. At this age level, children believe that if a person commits a wrong act unintentionally, or without knowing it is wrong, he should not be punished, or at least not so severely as if he committed a wrong act knowingly and intentionally.

Thus there develops what Piaget calls a *morality by agreement*. Rules of behavior are no longer thought of as imposed by an outside authority. A given act, such as cheating or telling tales, is considered bad, not because parents and teachers say it is bad, but because it is found by children themselves to be unfair or unpleasant to others who are the equals or peers of the doer of the deed. Piaget finds that from the age of six to the age of eleven or twelve morality by constraint gradually gives way to morality by agreement. The child's conscience becomes less subordinate to parents and adults and more subordinate to his age-mates.

The two kinds of morality are both present in an adult, but the morality of cooperation or agreement usually dominates by the end of childhood. This kind of morality provides for a sense of individual moral responsibility because it is learned in an atmosphere of free give and take among equals. Piaget says, "Rules due to mutual agreement and cooperation . . . take root inside the child's mind and result in an effective observance in the measure in which they are incorporated in an autonomous will."[1] Thus the children's culture is effective in developing moral ideas and moral judgment in the child. This is one important function of the children's world.

Another function of the children's world is to develop social behavior and social interests. Through his life with his age-mates the child learns to play and work together with his peers. If he does not associate with other children of his own age, he grows up to be a queer, unsocial person.

A great deal of study of the social behavior of children has given us a fairly clear picture of the normal course of social development when the children's world operates freely. A child of preschool age usually

plays in a solitary way unless an older child or an adult organizes a game which involves a group of children. Contacts between children at this age are brief, sometimes hostile or aggressive, sometimes friendly, but always casual. Close friendships are not formed. As the child grows older, he forms mutual friendships with other children, first as a member of a pair and then as a member of a group of three or four or more. Moreno studied the development of social groupings among school children by asking them to name classmates with whom they would like to sit or whom they would like to have in the same class during the following semester.[2] He found, in the kindergarten, that 35 per cent of the children were not chosen by any of their classmates. There was a decrease in the percentage of "isolates" through the first four grades, to 18 per cent in the fourth grade. This proportion then remained constant through the eighth grade. The mutual pair, in which two children each chose the other, was a frequent combination at the kindergarten level. This was supplemented by more complex groupings of three or more as the children grew older. In the eighth grade, more than half of the children were included in groupings of three or more. Until the age of eight, mixed-sex groupings were common. From eight to thirteen, one-sex groupings were the rule. After thirteen, mixed-sex groups appeared again with growing frequency.

The children's world teaches social behavior and social interests appropriate to age and sex. For example, consider the development of sex differences in games. There is practically no difference between boys and girls at the age of five in their group games. By the age of nine or ten, there are marked differences. The sex difference is best observed when both sexes play the same game. A baseball game was observed by the writer between fourth-grade boys and girls. The boys were fiercely competitive. They were intent on the game, even though the score was heavily in their favor. They objected vigorously and noisily if the umpire made a close decision against them. The girls, on the other hand, appeared to have no interest in the competition. They paid little attention to the game. The second baseman, shortstop, third baseman, and left fielder would form a little cluster in their section of the field and hold an animated converstaion while the pitcher pitched and the game went on. Lack of knowledge of the game, lack of skill, and a lopsided score undoubtedly combined to

reduce the girls' interest and competitive spirit. But, in addition, there was a clear difference of attitude and interest between the sexes, that was due neither to physical differences nor to differences in skill and knowledge. The children's culture, influenced undoubtedly by the adult culture, had taught these youngsters how to behave as boys and girls and what things to be interested in.

A third function of the children's world is to develop standards of personality and of social behavior. Age-group standards influence language, dress, and the surface traits of personality. This influence grows to a maximum during adolescence.

Standards change with age. What is approved in the peer culture of twelve-year-olds may be disapproved in the peer culture of fifteen-year-olds. Tryon showed this in her studies of the reputations of junior high school boys and girls.[3] She used the "Guess-Who" technique, asking boys and girls to name classmates who corresponded to one-sentence character sketches. She then found the attributes which were associated with popularity. Among boys of twelve, the most popular were said to be daring, leaders, interested in active games, and unkempt. Among the same group of boys at fifteen, the principal change from the earlier approved pattern was the substitution of tidiness for unkemptness in the constellation of desirable attributes. Among girls of twelve, the popular girls were thought to be friendly, tidy, and good-looking. In general, the adult-approved traits were attributed to the popular girls at this age. The same girls at fifteen attributed the qualities of enthusiasm, daring, leadership, and humor to popular girls. In short, being a good sport and attentive to boys constituted the approved pattern. There is no doubt that the peer culture was encouraging the development of these traits in boys and girls.

RELATION OF THE SCHOOL PROGRAM TO THE CHILDREN'S WORLD

The conventional school program runs along parallel with these influences of the children's world. The program is designed by adults to teach children certain skills and habits which parents do not have time or ability to inculcate. In the past, the school program was not generally supposed to be concerned with the social behavior or the social interests of boys and girls. It was, however, supposed to impress certain standards of conduct and certain moral ideas on the child through precept and punishment. Thus it imposed a morality of constraint.

In recent years a revolution of thought about the functions of the school program has made people see this program as something concerned with all aspects of the child's mental, social, physical, and personal development. Accordingly, it has become important to consider how the school program should be related to the influences of the children's world which affect the child's mental, social, and personal development.

The first observation to be made concerning this relationship grows out of the fact that the influence of the children's world is not always good for all children. We cannot trust the children's world to inculcate the right morality and the right social behavior in all children or at all times. For example, children can be fearfully cruel to one of their number. The cruelty of children to one another often makes adults cringe. Another example is the influence of the peer culture in certain disorganized urban areas, which leads to delinquency as a natural end-point for normal children. Still another example is the childishness and immaturity of standards of conduct sometimes approved by the peer culture among adolescents.

Therefore, it appears that the school program may well be aimed to correct the influence of the children's world at some points and to supplement it at others. This is in addition to the other and more conventional functions of the school program.

One example of supplementation of the children's culture by the school program is the development of democratic attitudes. The attitudes necessary for democratic living include those of cooperation and respect for others as equals. These attitudes are encouraged in the children's world by the development of a morality of cooperation. But if the school attempts to inculcate a morality of constraint, through rules rigidly imposed by the adult authorities, this will hinder the development of democratic attitudes. If the teacher becomes a kind of priest of society, and the school a kind of monarchy founded on divine right, democratic attitudes will either not be developed by children or they will be developed in spite of the school.

The school may well supplement the children's world in this respect by encouraging children to take responsibility for making many of their own rules. The school may also encourage group projects and other forms of collaboration which give practice to children in cooperation.

An example of needed correction of the children's world by the

school program is the treatment of the child who is socially isolated. There appears to be no natural corrective in the children's world for the child who is timid and afraid. Such a child becomes a social isolate, subject to much unconscious cruelty. Suppose such a child, a seven-year-old girl, approaches Valentine's Day. There is a box in a corner of the schoolroom where valentines are put, to be distributed when the Day arrives. She puts in several valentines, addressed to the popular boys and girls whom she has admired from a distance, but never spoken to. She hopes and hopes that she will get a handful of valentines, to show that many people care for her, even though they do not show it by playing with her. When the box is opened, the teacher reads off the names one by one and the children walk up to the front of the room, all red and proud to have this token of their popularity. The little girl waits and waits, but her name is not called. She takes out a book from her desk and tries to appear unconcerned. She gets away as soon as possible after school. She walks home, alone as usual, with a growing lump in her throat. As she reaches the door, she bursts out crying and sobs out to her mother that nobody likes her. She didn't get a single valentine.

The children's world conceals many tragedies like this one. Here the understanding teacher can intervene skillfully. She can help the isolated child to make friends and to develop self-assurance. She should have a good picture of social relations in the class, gained from observation on the playground and perhaps from the use of simple versions of Moreno's technique to locate the social isolates.

These examples are chosen to illustrate the importance of the school's doing things to supplement and correct the effects of the children's world. If the teachers in a school would study the children's world in their vicinity, and then would plan their own program in the light of this knowledge, they might considerably increase the value of their work.

BIBLIOGRAPHY

(1) Jean Piaget, *The Moral Judgment of the Child*, p. 365. New York: Harcourt, Brace & Co., 1932.

(2) J. L. Moreno, *Who Shall Survive?* Washington: Nervous and Mental Disease Publishing Co., 1934. Pp. xvi + 440.

(3) Caroline McCann Tryon, *Evaluations of Adolescent Personality by Adolescents.* Monographs of the Society for Research in Child Development, Vol. IV, No. 4. Washington: National Research Council, 1939. Pp. x + 84.

THE THERAPEUTIC VALUE OF PUPPETS

By Jeanetta Lyle and Sophie B. Holly, R.N.*

Eleanore Duse said, "Lying between dream and reality, the marionette can be made perfect when it is guided by a soul." The motto of Ivo Puhonney, the German puppeteer, was "A good marionette is of greater value than a living mediocrity." These people were of the theater and were speaking of the puppet as a dramatic medium, but their words help to express the sentiment awakened by the "little wooden men" which can be turned to account in a therapeutic program.

The educational value of puppetry is less well known than its entertainment and commercial values. Puppets have long been used in schools, however, where they lend themselves ideally to the teaching of such subjects as geography, history, home decoration, dress design, stage craft and dramatics. Their therapeutic possibilities in a program of *re-education* of the mentally ill have been recognized comparatively recently. Child therapy has utilized them most effectively in attempts to learn more about the nature of the child's conflicts which, with his limited vocabulary, he is unable to express adequately in words but can express in play with dolls and toys. A number of reports of this type of work with maladjusted children under the guidance of child analysts has been published.

The reaction of adult patients, who may also be unable to express their conflicts verbally because of regression and strong inhibitions, to puppet making and use has been less adequately studied, although some observations have been made. This method of recreation in a hospital is prescribed as is any other activity, mental or physical, for the purpose of contributing to lasting recovery from disease. It serves the therapist as a means of investigating the patient's difficulties and of helping him to solve them, and it helps the patient to dramatize his fantasies in a creative way. It leads, almost inevitably, to some kind of social relationship, because wherever there is a dramatic representation there must be an audience, even if it is only one person.

One of the best things about puppetry as a therapy is that it is so

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versatile. A puppet may play many rôles, not only on the stage, but in the treatment of patients. For one person the building of a being that walks and talks may satisfy a deep creative urge; for another the complete control which he gains of the puppet's mechanism may expand his ego by giving him a sense of mastery; for another the antics of the puppet may express the exhibitionistic strivings which he cannot give vent to himself; and for another the puppet may become an agent through which he can express inhibited aggressiveness.

This versatility of puppetry also makes it possible to hold the interest of a patient through many stages of his progress in the hospital. Between the mixing of raw materials for the manufacture of a puppet and the writing or adapting of a play for a marionette theater there are dozens of opportunities to utilize developing interests and talents of a patient.

A young male schizophrenic with artistic ability was given the responsibility of making a puppet. At that time he was depressed and could only follow explicit directions for each step from the therapist. His interest was so great, however, that he soon began to experiment in modeling heads, using clay, paper and wood. Then he turned to fashioning bodies for his figures and when these were completed to his satisfaction, he adapted fairy stories as dramatic vehicles for his actors. The next step was to produce plays and for this he needed the co-operation of other patients. In working with the toy figures that peopled his world, he gained self-confidence and voluntarily undertook to coach other patients in producing marionette shows in the hospital. The social progress which these increasingly complicated steps indicated seemed motivated by his wish to carry through a continually expanding project.

The concentration required and the necessity for fine mental and physical coordination in manipulating the controls of a puppet are especially good for excited patients. A manic patient was given the responsibility of operating one of the puppets in a play. At first he found it hard to manage the doll according to the given instructions, but accepting the difficulty as a challenge, he characteristically used his own judgment, making many changes and adding new features which enabled him finally to completely master the movements of the puppet. He was delighted with his ingenuity in overcoming the resistance of the doll and took satisfaction in having introduced some new ideas on his own initiative.

In many instances puppets are identified with real persons such as the patient's mother, father or siblings, and the patient derives pleasure in dressing and undressing them and ordering them around according to his wish. More commonly, however, no conscious identifications are made but the patient shows the nature of his anxiety in symbolic play with the materials or figures given him. Such play is especially adapted to allow free expression to infantile aggressiveness without arousing conscious guilt feelings in the individual.

A fourteen year old girl was brought to the sanitarium for treatment in a restless, bewildered and hysterical state. She suffered excessively from severe pre-menstrual cramps, and the history revealed that menstruation had come to her as a physical and mental shock. She had been given very inadequate enlightenment concerning it, and her distress and fright were so great that she had run away from her home. In the sanitarium, when she was given an opportunity to construct a dramatic scene using clay and figures, she modeled wild, ferocious animals and an Indian totem pole. In explanation of the scene she said, "I will not live in such a place because there is nothing to eat, no place to sleep and there are continual threats of punishment." It was seen that the modeling, in giving this girl an opportunity to express her fears symbolically, helped her to externalize her anxiety and gave the therapist a more exact insight into the nature of her preoccupations.

Patients often use puppets to depict scenes of execution. Settings in which the puppet is hanged are most commonly chosen, perhaps because the mechanics of the puppet suggest this form. The second most common form of killing the puppet is by choking him to death. One great advantage that puppet shows have over amateur dramatics is that such scenes of horror can be enacted without the gruesome reality that would attach to human players. One is reminded of the violent beatings which Punch administers to his mate to the great amusement of the onlookers in the oldtime Punch and Judy shows. But even such serio-comic aggressiveness is too much for some patients who choose to make figures more vaguely representative of terror and destructiveness, such as Indians, tigers and airplanes. It is interesting to see how some patients in modeling puppets often over-emphasize certain features to bring out aggressive characteristics, much as primitive artists do. The figure of the Giant in *Jack, the Giant Killer*, an ungainly, oversized puppet carrying a huge club, was very popular

with the patients although he received a good deal of knocking around, both on and off the stage.

Sometimes a patient identifies himself with his puppet and cannot be parted from it, taking it to his room and even taking it home with him when he leaves the hospital. The puppet to him takes on a personality, just as Charlie McCarthy has developed an individuality for the radio public that is more real than that of many human performers. One young schizophrenic boy modeled a puppet that looked a little like himself. This puppet first played the part of Jack in *Jack, the Giant Killer*, and later appeared as Gluck in *The King of the Golden River*. Because of his ingenuous expression and the hero parts which he played, he soon became the favorite of all the patients and his "master" enjoyed the reflected glory. He enjoyed playing with "Gluck," had him outfitted with a new suit in the women's occupational therapy department, and took the puppet home with him when he recovered sufficiently to leave the hospital, much to the regret of some of the other patients who had also grown fond of the little mannequin. It was quite evident in this case that the success of the puppet brought to this youth the renewed hope and interest in life that a human friend sometimes gives.

One rather touching example of this close identification with a puppet was shown in a presentation of Robinson Crusoe. A depressed schizophrenic man who was manipulating the puppet who took the part of Friday came to the lines where Friday begs Crusoe not to leave him behind on the island. Standing on the bridge over the miniature stage, the patient forgot all about pulling the strings of the puppet and turning to the therapist with tears streaming down his cheeks, he recited the passionate plea not to be left alone directly to the therapist.

CONCLUSION

The therapeutic aim in the making and use of puppets is always focussed upon the individual. The appearance or the performance of the finished article is relatively unimportant, although an attractive, easily controllable puppet as an end result is to be desired for the patient's own satisfaction. The making of any useful or beautiful article is always of great constructive value to a patient, but when he creates a figure in his own image and it takes on a life of its own, his sense of achievement is akin to that of a person who participates in the creation of a real child.

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